

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9849 52-040061

318 1003

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED OCT 19 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb		c. CITY OR TOWN		Inside Limits	
		St. Louis				St. Louis		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		St. John's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 6157 Pershing Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last		Margaret Mary Burke		4. DATE OF DEATH		Month Day Year	
						October 12, 1962			
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR		
Female	White		4/23/1913	49	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
Housewife		At Home		West Frankfort, Ill.		U.S.			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE					
Joseph C. Maginnis		Bessie Crawford		Paul J. Burke					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No				Paul J. Burke, 6157 Pershing Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a)		Carcinomatous							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		Oral Cancer 1750							
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.							
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from		March 1960		to 10-12-62		and last saw her alive on		10-12-62	
Death occurred at		1:30 pm		m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE	(Degree or title)		22b. ADDRESS	22c. DATE SIGNED					
Albert H. Hoppe, M.D.			307 S. Euclid	10-13-62					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)			
Burial	10-15-62	Calvary Cemetery		St. Louis, Mo.					
24. FUNERAL DIRECTOR	ADDRESS		25. DATE REGD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE					
Albert H. Hoppe, Inc.,	4700 Washington Blvd.		OCT 15 1962	E. Smith, M.D.					

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Gay W. Wilkins

Licensed Embalmer No.

3575

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.